Summer Program 2003

To Whom It May Concern:

The enclosed application is for the Cambridge Recreation Summer Program 2003, for individuals with special needs.

Please fill it out in its entirety.
Only completed applications will be accepted.

Transportation information will be mailed to accepted campers under a separate cover.

Please Mail Completed Applications To:

Jessica Murphy
42 Grist Mill Road
Littleton MA 01742

I can be reached by pager at: 617-430-5582

Summer Program 2003

CAMP RAINBOW Application

Child's Name_____

Address_____

Phone Number_____

Parent/Guardian Name_____

Session(s) enrolled for:
(Please mark off each week that your child plans to attend)

Camp Hours: 9am-3pm Monday – Friday

____**Week 1**: June 30-July 3 **Please note that we will be closed on Friday the 4th of July**	___**Week 4**: July 21-July25
____**Week 2**: July 7-July 11	____**Week 5**: July 28-August 1
____**Week 3**: July 14-July 18	____**Week 6**: August 4- August 8
____**Week 7**: August l l-August 15	

Please note: The annual family picnic will occur during the last week of camp

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Child/Participant Name: _____

Date Of Birth: _____ Age: _____ Male/Female

Address: _____

City: _____ Zip Code: _____

Home Phone Number: _____

Parent/Guardian Information

Mother's Full Name: _____

Address: _____

Phone number where you can be reached during program hours
****This needs to be a guaranteed number that we can reach you at.****
_____

Father's Full Name: _____

Address: _____

Phone number where you can be reached during program hours
****This needs to be a guaranteed number that we can reach you at.****
_____

Guardian other than Parent: _____

Address: _____

Phone number where you can be reached during program hours
****This needs to be a guaranteed number that we can reach you at.****
_____

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Medical Authorization and Consent

This program makes every effort to keep all participants safe. In the event of an emergency requiring medical attention, every effort will be made to contact the parent/ guardian.

_____
Participant's name

If I (parent/guardian) cannot be reached, I authorize the staff from Summer Program ~ 2003 to transport my child to the nearest hospital for emergency treatment.

_____ _____
Parent Signature Date

Please list two emergency contacts for your child. These people should include adults with whom your child may be released to in your absence. This includes when the child is not met at the bus stop.

In case of emergency contact:

1. **Name: _____**

Address: _____

Phone: _____ Cell Phone:_____ Pager: _____

2. **Name: _____**

Address: _____

Phone: _____ Cell Phone:_____ Pager: _____

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Medication

If your child requires medication to be administered during any of the recreation programs, please complete and return the forms found on the last two pages of this packet. The forms need to be returned prior to attending the program.

All medications need to be hand delivered to the bus monitor or to the director.

ALL MEDICATION MUST BE IN THE ORIGINAL PRESCRIPTION BOTTLE BEARNING THE ORIGINAL LABEL. THERE ARE NO EXCEPTIONS!!

Allergies

My Child has the following allergies/ medical conditions:
1.
2.
3.

Does your child require an epi pen? Yes/No

Photography Release

Please complete the following section.

_____ I do

_____ I do not

give permission for my child/participant to be photographed for publicity purposes.

_____ _____
Parent Signature Date
For safety and identification purposes, please attach a recent picture of your child.

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Participant Information

Please tell us about your child. The more information we have, the better able we are to meet your child's specific needs. Our mission is to help all participants grow within this environment. The following information helps us prepare for meeting your child's needs. If you have any questions or concerns, please contact the director of the program in which your child is enrolled.

Please check all that apply:

Diagnosis:

____ADD or AD/HD
____Aspergers
____Downs Syndrome
____Autism
____Developmental Delay
____Mental Retardation
____Cerebral Palsy
____Learning Disabled
____Emotional Disabilities
____Behavioral Disabilities
____ OTHER (Please List)

____PTSD (Post Traumatic Stress Disorder)
____PDD
____ Physical Disability (Please specify)

What grade is your child currently in? _____

My child is:

_____ Able to speak
_____ Unable to speak

_____ Able to use public transportation
_____ Able to state own name, address and phone number
_____ Aware of any allergies that he/she has

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Participant Information Continued

Please check all that apply:

My Child is able to:

_____ Get dressed on own
_____ Use self-care skills (brush hair, brush teeth etc…)
_____ Toilet independently
_____ Toilet with assistance
_____ Is not yet toilet trained

My child communicates using:
_____ Words
_____ Communication Board
_____ Sign Language
_____ OTHER (Please List)

_____ Walk independently
_____ Walk with assistance (crutches, cane, walker)
_____ Needs a wheelchair

My Child's first language is:
_____ English
_____ Spanish
_____ Creole
_____ French
_____ OTHER (Please list)

My child is afraid of:

_____ Being alone	**_____ Bugs, Bees**
_____ Being yelled at	**_____ Thunder**
_____ Dogs	**_____ Large Noises**
_____ Water	**_____ Cars, trucks**
_____ The dark	**_____ OTHER (Please list)**
_____ Large groups	

Please list any other information that you feel is important in order for us to best service your child.

Activity Release

I, _____ give my permission for _____
(Parent/ Guardian) (Participant)
to take part in activities/ field trips that are offered during program hours.

_____ _____
Parent/ Guardian Signature Date

Are there any activities that you DO NOT want your child to participate in? Please List:

_____

_____

_____

If there is any other information that you feel is important for us to know about your child, please include that on the bottom half of this page.

Parent/Guardian Consent for Medication Administration During Program Hours

General Information

Name: _____

Date of Birth: _____ Age: _____ M/F

Name of Parent/Guardian: _____

Address: _____

Telephone: (home)_____(Work)_____

Telephone during Program hours_____

Other persons to contact if parent/guardian is unavailable
Name: _____

Phone: _____ Relationship: _____

Please list all medications that the child receives both at school and home (if not a violation of confidentiality).

Food/Drug Allergies:

Consent

1. **I give permission for the director of the summer program to administer the following medication:**
   _____
   (Name of Medicine)
   Prescribed by:_____
   (Licensed Prescriber)
   to: _____
   (Child Name)

Signature of Parent/Guardian: _____